Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL QUALITY MEASURES CLEARINGHOUSE

General

Title

Non-OR procedural safety: percentage of wrong invasive or high-risk procedure events outside of the operating room per month.

Source(s)

Farris M, Anderson C, Doty S, Myers C, Johnson K, Prasad S. Non-OR procedural safety. Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2012 Sep. 38 p. [4 references]

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Outcome

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of wrong invasive or high-risk procedure events outside of the operating room per month.

Rationale

The priority aim addressed by this measure is to eliminate wrong site, side, patient or procedure events performed outside of the operating room.

Evidence for Rationale

Farris M, Anderson C, Doty S, Myers C, Johnson K, Prasad S. Non-OR procedural safety. Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2012 Sep. 38 p. [4

references]

Primary Health Components

Wrong invasive or high-risk procedure events

Denominator Description

Total number of non-operating room (OR) procedures per month (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

Number of wrong invasive or high-risk procedure events per month (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

Additional Information Supporting Need for the Measure

- As part of the Minnesota Adverse Health Event law, wrong site, procedure and patient events are reported directly to the Minnesota Department of Health and are disclosed to the public on an annual basis. Fortunately, while these events are very rare (1:50,000 invasive procedures including the operating room [OR]), facilities in Minnesota continue to work hard at preventing wrong site, wrong patient and wrong procedure events outside of the OR. The *Eighth Annual Public Report of Adverse Events in Minnesota* states that 36% of the total wrong site, patient or procedure events occurred in non-OR settings.
- An observational study has shown that ineffective team communication is often a root cause for a medical event, and ineffective team communications can have immediate, negative effects on patient safety.

Evidence for Additional Information Supporting Need for the Measure

Farris M, Anderson C, Doty S, Myers C, Johnson K, Prasad S. Non-OR procedural safety. Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2012 Sep. 38 p. [4 references]

Lingard L, Espin S, Whyte S, Regehr G, Baker GR, Reznick R, Bohnen J, Orser B, Doran D, Grober E. Communication failures in the operating room: an observational classification of recurrent types and effects. Qual Saf Health Care. 2004 Oct;13(5):330-4. PubMed

Minnesota Department of Health. Adverse health events in Minnesota: eighth annual public report. St. Paul (MN): Minnesota Department of Health; 2012 Jan. 104 p.

Extent of Measure Testing

Unspecified

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Ambulatory/Office-based Care

Ambulatory Procedure/Imaging Center

Emergency Department

Hospital Inpatient

Hospital Outpatient

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Single Health Care Delivery or Public Health Organizations

Statement of Acceptable Minimum Sample Size

Unspecified

Target Population Age

All ages

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Making Care Safer
Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

Getting Better

IOM Domain

Effectiveness

Safety

Data Collection for the Measure

Case Finding Period

The suggested time period is a calendar month, but three months could be consolidated into quarterly data points if caseload and/or event numbers are small.

Denominator Sampling Frame

Patients associated with provider

Denominator (Index) Event or Characteristic

Therapeutic Intervention

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions

Total number of non-operating (OR) room procedures* per month

Population Definition: Patients of all ages who have an invasive or high-risk procedure done outside of the OR (any non-OR setting).

Data Collection: Collect the number of total invasive or high-risk procedures done monthly. Determine from chart audits or event data whether any of these were wrong events. Event data should be reported through an incident or sentinel event report or per the organization's policy for reporting.

*Refer to Appendix A of the original measure documentation for a list of invasive, high-risk, or non-surgical procedures.

Exclusions

Unspecified

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions

Number of wrong invasive or high-risk procedure events* per month

*A *wrong event* is defined as a wrong invasive or high-risk procedure performed on the wrong patient, or a procedure performed on the wrong side, site or level.

Exclusions

Unspecified

Numerator Search Strategy

Fixed time period or point in time

Data Source

Paper medical record

Other

Type of Health State

Adverse Health State

Instruments Used and/or Associated with the Measure

Unspecified

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Desired value is a lower score

Allowance for Patient or Population Factors

not defined yet

Standard of Comparison

not defined yet

Identifying Information

Original Title

Rate of wrong invasive or high-risk procedure events per month.

Measure Collection Name

Non-OR Procedural Safety

Submitter

Institute for Clinical Systems Improvement - Nonprofit Organization

Developer

Institute for Clinical Systems Improvement - Nonprofit Organization

Funding Source(s)

The Institute for Clinical Systems Improvement's (ICSI's) work is funded by the annual dues of the member medical groups and five sponsoring health plans in Minnesota and Wisconsin.

Composition of the Group that Developed the Measure

Work Group Members: Marietta Farris, BSN (*Work Group Leader*) (Fairview Health Services) (Nursing); Christina E. Anderson, MD (Chippewa County – Montevideo Hospital & Clinic) (Family Medicine); Stephanie Doty, MSN, MBA, RN (HealthPartners Medical Group and Regions Hospital) (Patient Safety & Quality); Shailendra Prasad, MBBS, MPH (University of Minnesota) (Family Medicine); Kari Johnson, RN (Institute for Clinical Systems Improvement) (Clinical Systems Improvement Facilitator); Cassie Myers (Institute for Clinical Systems Improvement) (Systems Improvement Coordinator)

Financial Disclosures/Other Potential Conflicts of Interest

The Institute for Clinical Systems Improvement (ICSI) has long had a policy of transparency in declaring potential conflicting and competing interests of all individuals who participate in the development, revision and approval of ICSI guidelines and protocols.

In 2010, the ICSI Conflict of Interest Review Committee was established by the Board of Directors to review all disclosures and make recommendations to the board when steps should be taken to mitigate potential conflicts of interest, including recommendations regarding removal of work group members. This committee has adopted the Institute of Medicine Conflict of Interest standards as outlined in the report Clinical Practice Guidelines We Can Trust (2011).

Where there are work group members with identified potential conflicts, these are disclosed and discussed at the initial work group meeting. These members are expected to recuse themselves from related discussions or authorship of related recommendations, as directed by the Conflict of Interest committee or requested by the work group.

Christina Anderson, MD (Work Group Member)
Family Physician, Family Medicine,
National, Regional, Local Committee Affiliations: None
Guideline-Related Activities: ICSI Rapid Response Team Protocol
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Stephanie Doty, MSN, MBA, RN (Work Group Member)
Director of Patient Safety, Patient Safety and Quality Department, Regions Hospital
National, Regional, Local Committee Affiliations: None
Guideline-Related Activities: ICSI Rapid Response Team Protocol; ICSI Prevention of Retained Foreign Objects During Labor and Delivery Protocol; ICSI Perioperative Protocol; ICSI Committee on Evidence-Based Practice
Research Grants: None
Financial/Non-Financial Conflicts of Interest: holds stock in 3M

Marietta Farris, BSN, MAN (Work Group Leader)
Nurse Manager, Medical/Surgical, Fairview Health Services, University of Minnesota Medical Center
National, Regional, Local Committee Affiliations: None
Guideline-Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Shailendra Prasad, MBBS, MPH (Work Group Member)
Assistant Professor, Family Medicine, University of Minnesota
National, Regional, Local Committee Affiliations: None
Guideline-Related Activities: None
Research Grants: None
Financial/Non-Financial Conflicts of Interest: None

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2012 Sep

Measure Maintenance

Scientific documents are revised every 12 to 24 months as indicated by changes in clinical practice and literature.

Date of Next Anticipated Revision

The next scheduled revision will occur within 24 months.

Measure Status

This is the current release of the measure.

This measure updates a previous version: Institute for Clinical Systems Improvement (ICSI). Non-OR procedural safety. Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Aug. 31 p. [6 references]

The measure developer reaffirmed the currency of this measure in January 2016.

Measure Availability

Source available from the Institute for Clinical Systems Improvement (ICSI) Web site .

For more information, contact ICSI at 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; Phone: 952-814-7060; Fax: 952-858-9675; Web site: www.icsi.org ; E-mail: icsi.info@icsi.org.

NQMC Status

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Production

Source(s)

Farris M, Anderson C, Doty S, Myers C, Johnson K, Prasad S. Non-OR procedural safety. Health care protocol. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2012 Sep. 38 p. [4 references]

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